Stigma, Anchoring, and Triage Decisions

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A 43-year-old man walks to the ED front desk and reports to the triage nurse that he has thoughts of killing himself. During the intake interview, the nurse records stable vital signs except for a slightly elevated heart rate of 98 beats per minute. While the patient is escorted directly to a treatment area to care for his mental health needs, the patient also mentions having a 10/10 level of pain in his penis.

A 35-year-old man is brought to the emergency department by ambulance for alcohol intoxication after being found "passed out" at a bus station with a reported Glasgow Coma Scale (GCS) score of 7. The patient arrives smelling of alcohol, and his vital signs are stable except for a GCS score of 10 (eyes open to voice, speaks incoherently, and withdraws from pain).

A 74-year-old woman who is well known to the ED staff is brought to the emergency department by her son-in-law for reported depression. He tells the triage nurse, "She just keeps saying she wants to die…." The patient makes eye contact but does not speak during the intake assessment, even when asked direct questions.

In each of these cases, the triage nurse noted a primary mental health or substance use complaint, identified the patient as high risk, and assigned a level 2 triage acuity rating. Despite this relatively high triage acuity rating, each patient waited longer than the department average to see the primary nurse and the ED physician.

Was the department "really busy," or was there another possible reason for the wait?

Anchoring

Anchoring, or cognitive bias, is a term used in psychology to describe the effect of an initial decision on subsequent care.[1,2] Anchoring can temporarily influence attitudes, judgments, and, ultimately, patient assessment and interventions, resulting in overlooked assessment findings and potentially compromising patient safety. Clarke et al[1] and Grossmann et al[3] report mental health and geriatric patients as groups at increased risk for undertriage, despite use of a reliable and valid triage tool.

Patients presenting to triage with a self-diagnosis can set the stage for anchoring to occur during triage. For example, a husband brings his wife to the front desk and reports she has altered mental status after a seizure. The patient does have a history of seizures. The triage nurse may be influenced to anchor on seizure as the cause of the patient's altered mental status until learning the patient is also 24 weeks pregnant and suspecting that the symptoms may be attributed to eclampsia.

Stigma

Stigma is an unfair belief or negative social disapproval that can be overt, unconsciously intentional, or perceived. Labeling, stereotypes, and discrimination are forms of and contribute to stigma.[4] Hatzenbuehler, Phelan, and Link[4] describe stigma as a "fundamental cause of population health inequalities." Stigma has been linked to poor outcomes for patients seeking mental health care, and anticipated stigma was reported as a barrier to older adults seeking mental health care.[4,5] In examining how triage nurses make decisions related to patients with primary mental health complaints, Brown and Clarke[6] suggest that the attitudes of nurses may lead to possible stigmatization of patients seeking mental health care, resulting in delays in treatment.

A systematic review of the effect of educational interventions on the clinical decision making of nurses suggests that education methods cannot be relied upon to improve clinical judgment or decision making.[7] Additionally, Grossmann et al.[8] report that training specific to the triage algorithm does not decrease undertriage of elderly ED patients. However, Croskerry[2] recommends formal critical thinking training in medical and nursing classes to develop personal debiasing strategies.

What Can Be Done?

Awareness through recognition of personal biases, enhanced teamwork, and self-regulating mindfulness can reduce

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J Emerg Nurs 2016;42:87-8.
Available online 5 November 2015
0099-1767

http://dx.doi.org/10.1016/j.jen.2015.09.014

stigmatization and anchoring.[9] Clinicians with a habit of introspective scrutiny may also reduce instances of anchoring and stigmatic bias.[2] Being aware of personal perspectives and thinking about clinical decisions may further reduce bias and the tendency to anchor to an initial reaction.

During the triage process, an internal and possibly subconscious conversation would include questions about the worst possible and the most common clinical diagnosis. Observation of presenting signs and symptoms helps to determine a list of possible problems. The problem list is then narrowed through use of discerning questions to rapidly determine a triage acuity.

Scenarios Revisited

Remember the man with suicidal ideation and a painful penis? The report given to the primary ED nurse by the triage team focused on the risk of harm to self. Had the triage nurse asked about injury causing the reported pain, the treatment team would have learned sooner about the self-inflicted near-amputation that led to hemorrhaging into the adult incontinence brief worn by the patient. Anchoring onto suicidal ideation without asking clarifying questions in response to an odd patient statement delayed the care needed by the patient.

For the patient who was inebriated, after several hours without the mental status improvement expected following alcohol metabolism, the ambulance run report was reviewed and a short reference to a possible altercation was noted. Computed tomography was performed and a finding of intracranial hemorrhage was noted, which completely changed the treatment plan. Stigma associated with substance use and abuse and anchoring to "just another drunk" nearly cost this patient his life.

Finally, the older woman whose family brought her to the emergency department to seek treatment for depression can be a challenging triage. Because she is well known to the department, is this "just Mary again," or is she not speaking because of a stroke? Could her change in behavior be related to an infectious process, with her frustration about not feeling well causing her to make statements of self-harm? Has she recently had a significant loss in her life causing her depression?

When you meet "Mary," what discriminating, clarifying questions will you ask? How can you accurately yet rapidly determine her triage acuity? What biases do you need to be aware of in yourself and your practice? What strategies can you use in your practice to reduce anchoring to a snap judgment and instead focus on an unbiased assessment? What other resources do you need to deliver safe patient care and make sound triage decisions?

Eliminating behaviors such as anchoring and stigma takes awareness and training. It can be an everyday process and a life-long goal. Consider talking with your colleagues and working together to deliver safe practice and safe, unbiased care.

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